Printed: 01/16/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING	 	01/13/2014	
WESTVIEW MANOR OF PEABODY			500 PEA	ESS, CITY, STA ABODY DY, KS 668			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LISC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ETION
F 000	INITIAL COMMENTS	3		F 000			
		s represent the findings Complaint Investigation					
	A revised copy of the provider on 1/16/14.	2567 was sent to the					
F 280 SS=D	483.20(d)(3), 483.10(PARTICIPATE PLAN	(k)(2) RIGHT TO INING CARE-REVISE (CP	F 280			
	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.						
	within 7 days after the comprehensive assessinterdisciplinary teams physician, a registere for the resident, and disciplines as determined, to the extent pratter resident, the resident, the resident legal representative;	re plan must be develope completion of the ssment; prepared by an and that includes the attent of nurse with responsible other appropriate staff in ined by the resident's naticable, the participation dent's family or the resident periodically reviewed and periodically reviewed of qualified persons a	nding ility n eeds, on of dent's				
	The facility had a cer sample included 12 r observation, record re facility failed to revise	eview and interview the e the care plan for 1 of 1 applied a wanderguard	e				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

(X6) DATE

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		01/	13/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•		
	W MANOR OF PEABO	DDY I	500 PE	ABODY				
_				DY, KS 668	66			
(X4) ID	SUMMARY ST			ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 280	Continued From page	e 1		F 280				
	Findings included:							
	J							
	- The 12/4/13 physici	ian orders indicated						
		agnoses that included:						
	Psychosis (any major							
		oss impairment in realit						
		isorder (a major mental						
	severe high and low r	eople to have episodes	OT					
	•	Minimum Data Set 3.0						
	assessment, dated 1							
	•	others and is understo	ood					
		lequate vision glasses.						
	•	sident scored 14 on the						
	(BIMS), Brief Interview	w for Mental Status, wh	ich					
		tion and displayed phys	sical					
	behaviors directed to	ward others.						
	The 12/2/12 care plan	a stated the resident we						
	=	n stated the resident was ounds without staff arou						
		eighbor's property. The						
		ident was unable to go						
	town without staff, rel							
		r disorder with inapprop	riate					
	behavior. The care pl	an instructed staff to m	onitor					
		ased anxiety, increased						
		him/her on visual chec	•					
		o would determine how						
		be done. The care plan						
		explain the reason he/s						
		acility grounds without to the resident. The car						
		ne staff, if the resident v						
	•	on the facility grounds o						
		the staff would look fo						
		's neighboring property						
		The care plan further st						
		e to locate the resident						
	staff would call 911, n							
	Administrator, resider	nt's family/guardian, and	d					
							1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE S COMPL	
		17E210		B. WING		01	/13/2014
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY		BODY	500 PEA	ESS, CITY, STATABODY DY, KS 6686		·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM,		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	physician. If necessorder for a wanderg prevent the resident grounds. (A wander is worn by a wander alert the staff a resident the staff a resident had left the occasions to walk at had left the facility's The 12/30/13 at 10:: indicated the resident had left the facility's The 12/30/13 at 10:: indicated the resident his/her own, within a physician's phone bracelet to be place and the staff placed resident's right ankle approximately 19.4 hour winds from the scattered clouds whoulding.) The 12/30/13 physic staff to place a wanderesident for safety to walking off the facility when on a walking of the facility when on a walking of the resident had the all times.	ary, nursing will request uard bracelet as needed from leaving the facility guard bracelet is a devicing resident in a facility the dent is attempting to go color at the facility guard bracelet in a facility the dent is attempting to go color at the facility ground the building and at property. 30 AM, nurse's notes and the staff left the facility grounds shirt on and the staff left to but the resident returned on the resident for safe the wanderguard on the example on the ground south southwest and the the resident left the color or grounds, or going to the total provent the resident from the grounds, or going to the color of the grounds, or going to the grounds.	et to se that to court an lso s with to d on ived d etty e om own	F 280			
		pajamas lying on his/her					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			CONSTRUCTION	(X3) DATE S COMPL	
		17E210		B. WING		01	/13/2014
	OVIDER OR SUPPLIER	•		RESS, CITY, STATE	, ZIP CODE	•	
WESTVIEW MANOR OF PEABODY				ABODY DDY, KS 66866			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY F OR LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 280 F 329 SS=D	Continued From p with a wanderguar On 1/7/14 at 4:02 verified the staff ha after applying the in On 1/7/14 at 4:40 stated the resident bracelet on due to shirt only and no constated when the wighter wanderguard will obtain the staff that Resid wanderguard braces afety awareness clothing for the ten 483.25(I) DRUG R UNNECESSARY I	rage 3 d around his/her right ank PM, Administrative Nurse ad not updated the care p resident's wanderguard. PM, Administrative Staff H t only has a wanderguard going outside in a long sl oat. Administrative Staff H eather warms up the come off and the wanderg ed to the resident's care p ly temporarily. or revise the care plan to in lent # 45 now had a elet on due to his/her lack including wearing inappro- inperature outside. EGIMEN IS FREE FROM DRUGS ug regimen must be free f	de. A lan deeved duard plan nform c of ppriate	F 280			
	drug when used in duplicate therapy); without adequate r indications for its u adverse conseque should be reduced combinations of the Based on a compresident, the facilit who have not used given these drugs therapy is necessars diagnosed and	s. An unnecessary drug is excessive dose (includin or for excessive duration monitoring; or without ade use; or in the presence of nees which indicate the did or discontinued; or any e reasons above. The ensive assessment of a ymust ensure that reside did antipsychotic drugs are unless antipsychotic drugary to treat a specific conditional documented in the clinicants who use antipsychotic drugs and the clinicants who use antipsychotic drugs and the clinicants who use antipsychotic drugs and the clinicants who use antipsychotic drugs are unless and the clinicants who use antipsychotic drugs are unless and the clinicants who use antipsychotic drugs are unless and the clinicants who use antipsychotic drugs are unless and the clinicants who use antipsychotic drugs are unless and the clinicants are unless are	g c; or equate lose a nts not lition				

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		17E210		B. WING	····	01/	13/2014
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDR 500 PEA PEABOL			•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	drugs receive graduate behavioral interventic contraindicated, in a drugs.	al dose reductions, and ons, unless clinically n effort to discontinue th		F 329			
	The facility had a ce sample included 12 residents were revie medication. Based of and interview, the far residents were free of The facility failed to opressure prior to me ordered by the physical process.	s not met as evidenced by nsus of 47 residents. The residents of which 5 wed for unnecessary on observation, record recility failed to ensure 2 confunnecessary medication administration a dician and failed to notify ician of outside parametran	e view of 5 ons.				
	Set 3.0 assessment the resident had a (E Mental Status score cognition. The assessindependent with all he/she had not displ the assessment perion of the updated 11/25/2 charge nurse to admits the session of the session of the updated 11/25/2 charge nurse to admits the resident of the session of the session of the updated 11/25/2 charge nurse to admits the resident of the session	13 plan of care directed thin interest of the state of th	ed tact dent and ng the				
	by the physician. The the charge nurse to pressure weekly and	e plan of care further dir obtain the resident's blood more often if deemed r for hypertension (high	ected od				

XTC511

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		01/1	3/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
WESTVIE	W MANOR OF PEABO	DDY	500 PE/ PEABO	ABODY DY, KS 668	66			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page	e 5		F 329				
	The 12/4/13 physiciar hold the Lisinopril (memg (milligram) at beding Blood Pressure) is less Review of the resident administration record; December 2013, Nov September 2013, and resident's blood pressprior to administering which had been indicated on 1/7/14 at 9:15 AM resident independent! On 1/8/14 at 2:40 PM physician's order was resident's blood press the Lisinopril was on thought it had been dine/she had only been blood pressure week!	n's order directed the stedication for hypertensitime if the SBP (Systolius than 100. It's MAR (medication of for January 2014, ember 2013, October 2014, ember 2013 revealed sure had not been obtain the Lisinopril at bedtimated on the MAR to do on, observation revealed y ambulating down the currently for obtaining sure prior to administering the MAR, although he/stiscontinued. Nurse C stipotaining the resident's y.	on) 5 c 2013, the ined e so. the hall. the ing she tated s					
	On 1/8/14 at 2:40 PM, Administrative Nurse A verified there had not been an order from the physician to discontinue obtaining the blood pressures prior to medication administration and would expect the staff to follow the physician orders.		and					
	Administration Proced check the MAR for the further directed the st vital signs or other mo	er 2009 Specific Medic dure directed the staff to e order. The procedure aff to obtain and record onitoring parameters ecessary prior to medic	o I any					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			STREET ADDRI 500 PEA PEABOL	, ,	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329	The facility failed to opressure prior to admordered by the physical Resident #40's and Set 3.0 assessment, resident had a (BIMS Status score of 15 who cognition. The assess independent with all a he/she had not displate the assessment period. The updated 11/11/1 staff to encourage the when getting up from of care further directoresident to use the haunsteady on his/her for the 12/4/13 physicial notify the physician if pressure was less the administering Norvas medication) 10 mg (not not not not not not not not not not	btain the resident's blockinistering medication action. (#20) fual (MDS) Minimum Datated 11/4/13, indicated bright indicated intact sment revealed the residentiaties of daily living, ayed any behaviors during a plan of care directed the resident to rise up slow the bed or chair. The part the staff to encourage andrail in the hallways if eet. In sorder directed the staff to encourage andrail in the hallways if eet. Medication Administration to a blood pressure hilligrams). Medication Administration to the pressures prior to the pressures that were set by the physician and the medication. The led no documentation to the of the parameters. In vital sheet revealed the vital sheet reveal	ata d the ntal dent and ng the wly olan e the f taff to on aining aining cord out d the he	F 329			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	1/1/14 - 120/78 12/25/13 -118/74 12/11/13 - 104/70 12/4/13 - 114/76 11/21/13 - 119/85 10/30/13 - 128/78 10/9/13 - 128/78 10/9/13 - 120/80 On 1/7/14 at 12:00 President seated at the independently. On 1/8/14 at 2:33 PN unsure if the physiciar regarding the blood pphysician's paramete that if it is not charted the physician had profon 1/8/14 at 2:45 PN stated the charge nur Bar (a form filled out information to be faxe and send a fax to the blood pressure's are then the staff are to conditional to the staff	M, observation revealed a dining table eating 1, Nurse C stated he/shan had been notified bressure's out of the ers. Nurse C further stated in the nurse's note's, the bably not been notified by the nurse regarding ed to the physician) sheen physician if the resident out of the parameters a chart it in the nurse's note a further stated he/sheen out of the physician or of the physician of the blood	e was ed hen . A ty's S et ht's hd tes. e ders. derts he	F 329		
		dure directed the start to e order. The procedure	-			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C		` ′	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		17E210		B. WING		01/1	3/2014
	OVIDER OR SUPPLIER W MANOR OF PEAB	ODY	500 PE	RESS, CITY, STA ABODY DY, KS 668	,		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 329	further directed the signs or other mordered or deemed radministration. The facility failed to opressure prior to admordered by the physician regarding to pressures that were by the physician.	staff to obtain and record conitoring parameters necessary prior to medic obtain Resident #40's bl ninistering medication a cian and failed to notify the resident's blood out of the parameters as	cation ood s the s set	F 329			
	FULL-TIME DON Except when waived this section, the facilit registered nurse for a a day, 7 days a week Except when waived this section, the facilit registered nurse to s nursing on a full time. The director of nursin nurse only when the occupancy of 60 or form. This Requirement is The facility had a cer sample included 12 review and interview a Registered Nurse 8	under paragraph (c) or ity must designate a erve as the director of basis. ng may serve as a charge facility has an average	(d) of s of a ours (d) of ge daily ov: ee ord ovide ay, 7	F 354			
	- Review of the Octo	bber, November, Decem	nber				

XTC511

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ELE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		01/1	3/2014	
	OVIDER OR SUPPLIER			RESS, CITY, STA	ATE, ZIP CODE	•		
WESTVIE	W MANOR OF PEABO	ODY		ABODY DY, KS 668	666			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 354	2013 and the January licensed nursing sche Registered Nurse cowhours on the following 1) October 2013-10/3 10/6/13, 10/12/13, 10 10/26/13 and 10/27/1 2) November 2013-11/10/13, 11/16/13, 1 11/29/13 and 11/30/1 3) December 2013-12/21/1/13, 12/20/13, 12/21/13, 1 12/25/13. 12/26/13, 1 times)	/ 2014 (through 1/9/14) edule revealed the lack verage for 8 consecutive g dates: /13, 10/4/13, 10/5/13, /13/13, 10/19/13, 10/20 3. (10 times) 1/2/13, 11/3/13, 11/9/13 1/17/13, 11/23/13, 11/2	of a e 0/13, 24/13. 5/13, 24/13,	F 354				
	verified the facility did consecutive hours of basis. The facility failed to p for 8 consecutive hour reside in the facility. 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	RN coverage on a daily rovide a Registered Nurs to the 47 residents vocume, ERVE - SANITARY sources approved or ry by Federal, State or estribute and serve food	rse vho	F 371				

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		17E210		B. WING	 	01/13	3/2014
WESTVIEW MANOR OF PEABODY			500 PE	RESS, CITY, STA ABODY DY, KS 668			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
TI TI Sa ol di co fro fro Pol ol the do pa di fio ki O he au st is pol fro F	the facility had a centample included 12 resistribute and serve for conditions for the 47 resonant of 1 kitchen. On 1/8/14 at 11:45 oon meal, revealed otholder on the floor baservation revealed to tholder as he/s oor and used the so an of swiss steak from 1/8/14 at 11:50 All dministrative Staff Hairnet, crossed the rea, and took a cartaining room area. The coor is to indicate how it includes the without a hair on 1/8/14 at 12:00 Ple/she knew the pothen he/she verified the hould not have been trained the sues and verified the otholder in a basket further stated that the	not met as evidenced be sus of 47 residents. The esidents. Based on view, the facility failed to cod under sanitary residents who receive not a subject to the facility staff G dropped in the kitchen. Further Dietary Staff G picked is the was opening the ovided pot holder to take come the oven. M, observation revealed the entered the kitchen will be red line by the food prout of the kitchen to the ered line on the kitcher we far you may enter the net. M, Dietary Staff G state holder had fallen on the line potholder was soiled	the da up en out a d thout ep en out a d floor and d the control the Staff en	F 371			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	17E210			B. WING		01/	13/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	I RESS, CITY, STA	TE, ZIP CODE			
WESTVIE	W MANOR OF PEABO	YDOY		ABODY	26			
			PEABO	DY, KS 6686			1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From page 11 on.			F 371				
	The facility failed to distribute and serve food under sanitary conditions for the 47 resident who resided in the facility.							
	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.		ORT	F 428				
			d					
	The facility had a cen sample included 12 re reviewed for unneces observation, record re facility's pharmacy co facility regarding the seriodent's blood presserved in the seriodent in	sures upon administrati	e e d on e the on of					
	Findings included:							
	Set 3.0 assessment of the resident had a (Bl Mental Status score of	rterly (MDS) Minimum dated, 11/20/13, indicat IMS) Brief Interview for of 15 which indicated in sment revealed the resi	ed tact					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING	·	01	/13/2014
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PEA	ESS, CITY, STA BODY DY, KS 668		·	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	independent with all he/she had not displ the assessment perion of the assessment perion of the updated 11/25/c charge nurse to adm by the physician. The charge nurse to pressure weekly and necessary to monito pressure). The 12/4/13 physician hold the Lisinopril (normal (milligram) at belied administration record December 2013, Normal September 2013, and resident's blood presprior to administering which had been indicated and interest of the Pharmal 12/23/2013, 11/27/2 revealed no irregular on 1/7/14 at 9:15 All resident independent on 1/8/14 at 2:40 Pliphysician's order was resident's blood prest the Lisinopril was on thought it had been at the same of the physician's order was resident's blood prest the Lisinopril was on thought it had been at the same of the physician's order was resident's blood prest the Lisinopril was on thought it had been at the same of the physician's order was resident's blood prest the Lisinopril was on thought it had been at the same of the physician's order was resident's blood prest the Lisinopril was on thought it had been at the physician's order was resident's blood prest the Lisinopril was on thought it had been at the physician's order was resident's blood prest the Lisinopril was on thought it had been at the physician's order was resident's blood prest the Lisinopril was on thought it had been at the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician's order was resident's blood prest the Lisinopril was on the physician the physician that the phy	activities of daily living, ayed any behaviors duriod. 13 plan of care directed inister medication as or e plan of care further directed in the resident's blood more often if deemed in for hypertension (high an's order directed the street of the secure of the secure of the case of the Lisinopril at bedtime cated on the MAR to do anacy Consultation record of 13, 10/23/13, and 9/19 rities for the resident. My observation revealed of the secure of the MAR, although he/secure of the MAR, altho	the dered ected od blood saff to on) 5 c c 2013, lethe ined lee so. ds for /2013 the hall.	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
17E210		17E210		B. WING		01/13/2014		
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY		DDY	500 PEA	ABODY DY, KS 668		·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 428	verified there had not physician to discontin to medication administ the staff to follow the The facility's Decemb Administration Proceed check the MAR for the further directed the st vital signs or other moordered or deemed not administration. The facility's pharmacof the staff not obtain pressure prior to admordered by the physical resident #40's ann Set 3.0 assessment, or resident had a (BIMS Status score of 15 who cognition. The assess independent with all a he/she had not displat the assessment periodical resident to use the had unsteady on his/her fereigned.	l, Administrative Nurse been an order from the ue the blood pressures stration and would experiment of the corder. Set a corder. The procedure aff to obtain and recordering parameters ecessary prior to medical contioning parameters ecessary prior to medical contioning medication as contioning medicated intact sment revealed the resident revealed the resident to rise up slow the bed or chair. The production of the staff to encourage and continuing medicated the staff to encourage and the staff to encourage and the staff to encourage and continuing medicated the staf	ation o lany ation acility ata dent and ng the wly lan e the :	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
	17E210			B. WING		01/13/	2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
WESTVIE	W MANOR OF PEABO	DDY	500 PEA					
			PEABO	DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICIENCY)	E ACTION SHOULD BE DATE DATE DATE DATE DATE DATE DATE DAT		
F 428	Continued From pag	e 14		F 428				
	Record) revealed the the resident's blood p administering the Nor the blood pressures v record revealed multi were out of the paran physician and the sta medication. The med documentation the staresident's blood press parameters.	rvasc but had been obtaveekly. Further review of ple blood pressures that neters as set by the final administered the ical record revealed no aff notified the physicial sure when outside of the vital sheet revealed the	aining aining of the at n of e					
	Review of the Pharmacy Consultation sheet for 12/23/2013, 11/24/2013, and 10/23/13 revealed no irregularities for the resident.							
	On 1/7/14 at 12:00 Pl resident seated at the independently.	M, observation revealed e dining table eating	d the					
	unsure if the physicia regarding the blood p physician's paramete that if it is not charted		ed hen					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		01/1	3/2014
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PE	RESS, CITY, STA ABODY DY, KS 668		•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT		ULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 428	On 1/8/14 at 2:45 PN stated the charge nu Bar (a form filled out information to be fax and send a fax to the blood pressure's are then the staff are to a Administrative Nurse would expect staff to Review of the facility medical record reveastaff had notified the pressures outside of The facility's December 1.	M, Administrative Nurse rese is to fill out the facility the nurse regarding ed to the physician) sheet physician if the resider out of the parameters a chart it in the nurse's note A further stated he/sheet follow the physician orders. See Bar forms and residued no documentation to physician of the blood the set parameters.	ty's S et int's ind ites. e ders. dent's he	F 428			
F 441 SS=F	further directed the signs or other mordered or deemed radministration. The facility's pharmathe facility regarding Resident #40's blood administration of merphysician and the fairesident's blood president's blood president's blood president's PREAD, LINENS The facility must estallifection Control Pro	dication as ordered by tilure to notify the facility sures out of the parametan. CONTROL, PREVENT ablish and maintain an gram designed to provious officials and maintain evelopment and	ation otify he of a eters	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		17E210		B. WING		01/13/2014			
WESTVIEW MANOR OF PEABODY 5			500 PE	T ADDRESS, CITY, STATE, ZIP CODE 0 PEABODY EABODY, KS 66866					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION			
F 441	Program under whice (1) Investigates, con in the facility; (2) Decides what prospond should be applied to (3) Maintains a record actions related to inform (b) Preventing Spread (1) When the Infection determines that a respression to the spread of isolate the resident. (2) The facility must communicable disease from direct contact will train (3) The facility must hands after each direct and washing is indiprofessional practices. (c) Linens Personnel must hands	Program ablish an Infection Contr h it - trols, and prevents infections, and prevents infections and individual resident; are of incidents and correspections. and of Infection and Control Program sident needs isolation to of infection, the facility material prohibit employees with use or infected skin lesion with residents or their food insmit the disease. Trequire staff to wash the ect resident contact for wicated by accepted	ctions ion, and ctive ust a ns od, if eir	F 441	DEFICIENCY)				
	The facility had a ce sample included 12 observation, record facility failed to provi comfortable environdevelopment and tra	s not met as evidenced by nsus of 47 residents. The residents. Based on review and interview, the de a safe, sanitary and ment and to help preventansmission of disease aresidents residing in the factorial sales.	e e t the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E210		B. WING		01/	13/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
	W MANOR OF PEABO	YDY	500 PE	ABODY				
				DY, KS 668	66			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From page	e 17		F 441				
	Findings included: - On 1/07/2014 at 9:35 AM, observation revealed							
	Housekeeping staff B applied gloves and preceded to spray a resident's sink and toilet with a mixture of Lysol and water, then immediately wiped the sink and toilet with a white cloth rag.							
	Housekeeping staff B then sprayed the mirror with a generic window cleaner spray. Housekeeping staff B used Comet to clean the inside of the toilet, and sprayed the Eco lab lemon							
	lift (a heavy duty cleaner and destainer specially formulated to remove mold and mildew) on the top of the sink and around the toilet bowl.							
	Housekeeping placed the cloth rag in a plastic bag on the side of the housekeeping cart for the laundry to wash.							
	On 1/07/2013 at 1:10 PM observation revealed Housekeeping staff B sprayed the dining room tables with a mixture of Lysol and water, and immediately wiped down the tables with a white cloth rag.							
	On 1/09/2013 at 9:30 AM, Housekeeping staff D stated the housekeeping staff clean the residents' room daily with the Lysol and water spray mixture, use the Lemon lift spray and then would dry mop the residents room. Continued interview revealed the housekeeping staff are to wet mop the residents' floors once a week or as needed.		ould view					
	On 10/09/2013 at 9:30 AM, Housekeeping staff D stated the housekeeping staff are informed of infections from the nurse, and the resident's room will have a isolation sign on the resident's door. He/she stated if there is an employee who "likes to talk" they will withhold the particular type of virus/bacteria or infection and just inform them to							

			X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E210		B. WING		01	/13/2014		
NAME OF PROVIDER OR SUPPLIER WESTVIEW MANOR OF PEABODY			500 PE	RESS, CITY, STAT ABODY DY, KS 6686	•	·			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA		(EACH DEFICIENCY MUST BE PRECEDED		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	revealed the staff and counters, bed frame a multi-purpose, ne and deodorant) on the use a bleach concer Housekeeping staff use bleach in the base bleach in cleaning produced in cleaning prod	utions. Continued intervier to use Lysol to clean the set, woodwork and Oasis utral pH, germicidal determination of 1 to 10. Described the staff were athrooms. al Safety Data Sheet) contained Isopropyl (a secondary) and Ethanol (alcooducts) and Ethanol (alcooducts). Cleaning and Disinfecting directed the housekeeping sidents' bathroom sinks a cetant, and the manufacture followed for proper use or gent) products. provide a safe, sanitary ment and to help prevent ansmission of disease for	he 531(rgent rgent rs to to blyent bhol ng g and res f and t the	F 441					